The Program's Major Departures from Hoosier Healthwise

- Participation is not limited to HMOs
- Respondents must be in-state plans, i.e., must have an Indiana license at the time of submitting a bid
- POWER Account and deductible health plan design
- Focus is on providing incentives for staying healthy, being value- and cost-conscious and utilizing services in a cost-efficient manner
- OMPP recommended preventative services based on age, sex and pre-existing conditions
- POWER Account operations: pre-paid debit cards, balance roll-over and rebates
- Plans must offer members the opportunity to purchase vision and dental coverage
- Reimbursement is based on Medicare rates
- Statewide, not regional, participation by Plans
- Pregnancy-related services are excluded
- Not an entitlement; enrollment will be capped based on available state resources
- Plan, or affiliate of Plan, must offer individuals ineligible for state-subsidized coverage an opportunity to buy into its product being provided under the Program
- Specific key staff positions not being mandated by the State (with the exception of Key Contact, Compliance Officer and any other positions required under IDOI license)
- No DUR Board review
- Financial stability requirements limited to IDOI and CMS requirements
- Self-referral services generally limited to CMS requirements (Family Planning and ER)
- $50 co-pay for non-emergency services obtained in ER setting
- Specific behavioral health policies not being mandated (with the exception of mental health parity)
- In addition to Asthma, additional disease management programs being mandated: Diabetes, Congestive Heart Failure and Chronic Kidney Disease
- Plans not restricted by a generic drug mandate (although cap rate only covers generic drugs)
- Moving toward paperless system (EOB statements e-mailed, etc); Plans will establish e-mail accounts for members that do not have one or request a separate e-mail account for Program communications
- Application through Plans, and Plans must assist members in recertification process
- Proof of state residency eligibility requirement
- More aggressive marketing by Plans (within CMS guidelines)
- No enrollment broker; if an individual applies through a Plan, he or she must check box indicating knowledge that other Plans exist - Plans do not provide further counseling about other options

- Plan selection at time of application
- "General health questionnaire" and referral to State's high-risk plan
- Family members must all enroll in same Plan (ease of administration in collecting POWER Account contributions); exception for family members referred to the State's high-risk plan
- Coverage under Plan does not begin until 1st POWER Account contribution processed (qualified enrollment until paid; member has 60 days to pay)
- Members have 10 days to return policy pursuant to state insurance laws (asking for waiver of CMS requirement that members have 90 days to change Plans after initial enrollment in Plan)
- Geographically balanced marketing by Plans required
- Additional member educational and outreach materials required, including education about preventative care, POWER Accounts and cost/quality
- Member grievances and appeals may depart from HHW, depending on standards adopted by OMPP pursuant to IC 12-15-44
- Less stringent PMP requirements and PMP enrollment/disenrollment procedures
- Additional provider education and outreach requirements, including education about reimbursement with POWER Account funds and pregnancy-related services exclusion
- Additional reporting requirements (geographic coverage, POWER Accounts, etc) and performance measures (POWER Account performance, etc)
- Plans encouraged, but not required, to establish provider pay-for-performance programs or member incentive programs
- Plan incentive programs may be developed, but not established at this time